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STATE DOCUMENTS

HJR Committee Finds Health Needs To Be Low Priority

JUL 3 1974

After more than three months of work by six members of the Study Committee, the first phase of the study design for House Joint Resolution 18, intended to examine present public health services in representative areas of the state, is nearing completion.

Utilizing a Committee-designed standard response format and collecting both objective and subjective information, the team has been conducting field interviews in three separate counties representing a wide spectrum of public health services delivery.

The interviewing teams, consisting of one health consumer and one elected state legislator, conducted their studies in one county with minimal or no public health services, in another with some fragmented public health services, and in a third offering many services in a somewhat coordinated system.

The committee asked that the counties not be named.

With the completion of the field interviews and the analysis of the information, it is becoming increasingly clear to the study committee what a can of worms the public health service delivery system represents.

The direct consequence to the committee's work, a recommendation to the 1975 Legislative Session, will have to address a system that is marked by a lack of support by the people, local elected

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MONTANA COMPREHENSIVE HEALTH PLANNING NEWS

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2 Volume 5, Number 4 — May - June, 1974

'b' Agencies to Be Reimbursed

For the past 18 months, the areawide "b" agencies have been conducting comment and review activities on approximately 40 applications for new health facilities and modifications on existing ones in compliance with Section 1122, Title XI of the Social Security Act (PL 92-603).

The January-February issue of the **CHP NEWS** contained an article on Section 1122 which described its intent to assure that federal Medicare, Medicaid, and Maternal and Child Health funds are not used to support any unnecessary capital expenditures made by or on behalf of a health facility or health maintenance organization.

Among the elements of administration of the 1122 review and comment function is one concerning the reimbursement to the Designated Planning Agency (DPA) which makes the final decision regarding approval or disapproval of proposals under Section 1122. In Montana, the DPA is the Department of Health and Environmental Sciences.

Up until now, the areawide CHP agencies and the Department of Health and Environmental Sciences have had to pull resources from other areas of their budgets to finance their review and comment procedures.

Nevertheless, the areawides will soon be reimbursed for those expenditures by the Social Security Administration via the state DPA with whom it has the contracts for Section 1122 review and comment activities.

The reimbursement funds will be applied toward the staff time spent in Section 1122 review, the travel expenses of committee members attending review hearings, and other miscellaneous costs incurred such as reproduction of printed matter and newspaper space.

The method of determining the amount of reimbursement is some-

—See page 2

Campbell — Formulas, ratios, percentages.

B-Grant Submitted $198,284 Aid Sought

At or around this time of year, CHP, like many other agencies is required to make application for grants to cover operations for the upcoming fiscal year. On May 1, a request for the Cooperative Areawide Comprehensive Health Planning Grant was submitted to the regional office in Denver.

The grant request petitions the Health Services and Mental Health Administration (HSMHA) for a total $198,284 for fiscal 1975.

According to Warren Brass, Planning Coordinator for Areawide Affairs, these monies will be distributed among the areawide "b" agencies.

Brass was assisted in his preparation of the request by Ms. Judith Carlson, State-Regional Coordinator. Ms. Carlson worked closely with the regional office in Denver while writing and submitting the grant proposal.

Once approved, the grant would provide 75% of the agencies' basic funding the remaining 25% to be composed of matching state and local resources.

Although the grant would provide a considerable sum for the areawides, Brass emphasized the importance of continued local matching.

"Areawides are encouraged to provide local matching funds to further enhance the possibility of their receiving additional federal funds," he said adding, "This also indicates local support and committment for the program."

For the first time, this year's grant application incorporates a concept of "new federalism" according to Brass.

With a spirit of "new federalism" in mind, the federal government is supposed to trust the state in keeping record of day-to-day materials such as by-laws, boards of directors, etc.

"These no longer have to be included with the grant application but must be kept on file in the state office," Brass stated.

In the past, the applications for grants have been accompanied by pages of technical information about the agencies which often reached voluminous proportions and ultimately slowed the process of review.

Concerning the specific requests from the areawides, the federal funds sought by the agencies are as follows:

Northwestern	$33,213
Northcentral	22,878
Eastern	27,708
Southwestern	54,362
South Central	40,581
State "a"	19,542
	$198,284

Reimbursement—

—Continued from page 1

what different from other sources of income such as grants which are requested on the basis of budget predictions.

Explained Cathy Campbell, CHP Health Planner, "The amount of reimbursement is determined by a formula. First the CHP expenditures for the entire state are multiplied by the percentage of effort CHP agencies spend in cost containment, that figure not allowed to exceed 50%.

"That product is then multiplied by the ratio of federal expenditures under Medicaid, Medicare, and Maternal and Child Health Programs for nursing home and hospital care to the total expenditures from all sources for hospital and nursing home care within the state.

"Montana," Ms. Campbell continued "has a much higher percentage of its hospital and nursing home care paid for out of those federal funds. So we get more money to conduct Section 1122 reviews than most states. In fact, we get more money than any state in the region," she said.

According to the formula, that total amounts to $64,496 for fiscal year 1974.

As outlined in the Section 1122 regulations, the DPA may retain no more than 30% of the funds except as agreed by the U.S. Department of Health, Education and Welfare. The remainder of the money must go to the areawide CHP agencies.

The areawides will actually be getting more than 70%, but this is only the reimbursement for fiscal 1974. Beginning this coming July 1, there will be another reimbursement for fiscal 1975.

Concerning the method of distribution, Campbell said, "This first year (fiscal 1974) the areawides will get about equal amounts if they can justify it, which I believe they can. For future years, they will project how much they plan to spend, and it may show that some areawides will spend more than others. Right now, there is no more fair way to do it than to divide it up evenly."

Fortunately, neither the areawide CHP agencies nor the Department of Health and Environmental Sciences will have to dip into the till to conduct future reviews this coming fiscal year as the anticipated $64,000 will come beforehand.

ON THE MOVE

The Southwestern Areawide Health Planning Council Offices, formerly located at 510 Logan, Helena, have moved to new facilities.

The Executive Director's new offices are now located at 324 Fuller Avenue, Helena. SWAHPC can now be reached at 449-2825.

HHA—Bringing It All Back Home

Begun last October, an experimental home-care nursing program was devised through the efforts of the Southwestern Areawide Health Planning Council enabling many Helena residents to obtain needed health services in the home rather than in the hospital.

With a staff of two nurses, Sr. Elizabeth and Noreen Baretch and an aide, Pam Templin, the Lewis and Clark Home Health Agency helps in alleviating some of the overload at St. Peter's Hospital as well as saving many people the expense of rapidly rising hospital costs.

Concomitant with the ensuing demand for health services, it was

Luck: Independence and dignity.

discovered that many of those heretofore provided by the hospitals could be made available to the public through other means, according to Jim Foley, Director of the SWAHPC.

"Through the program we discovered that 25-30 people a day could have been treated at home rather than in the hospital," Foley said.

When an alternative to hospitalization is mentioned, one element in particular comes to mind: money. At this time, a private room at St. Peter's costs $55 per day. A semi-private one goes for $50 per day and a bed in a ward for $45.

The health care agency is a blessing in that category. A visit from the nurse is $10. One from the nurses' aide who can provide personal hygiene and related services is only $6.

According to Holly Luck, President of L&CHHCA's Advisory Board, "This is a considerable savings when you consider what it costs to simply walk into a doctor's office. It's far cheaper than going to the doctor frequently or even to the hospital as an outpatient.

"Some insurance companies," Ms. Luck continued, "have home health care plans, but most do not. So this is a considerable savings for the Medicaid and Medicare programs as well."

In addition to providing an alternative to the hospital, the home health care concept supplements the services of existing visiting nurse programs.

"Visiting nurse programs are preventive in nature and services. As opposed to the public health care, the home health care nurse can come into the home and examine the patient afterward passing that information along to the doctor," Ms. Luck pointed out.

With that information in hand, the doctor can then make further prognoses without the expense and effort of an appointment. However, the benefits of such a program are not bounded by financial and expedient considerations alone.

"For the elderly, this type of health care is particularly advantageous, because it provides them with the services in the privacy of their own home. This permits them a certain amount of independence and dignity in their treatment," Luck added.

Prospects for continuation and expansion of the program which now includes some 30 patients are bright according to Foley.

"We were able to begin the program with a $10,000 grant from the Intermountain Regional Medical Program in Salt Lake City, for six months. It is our intention to have the program become self-supporting by the end of July."

The approach to financial autonomy being taken by the program's framers is to confront the companies writing health insurance policies with the concept.

Fortunately, the program has been enthusiastically received among those of the medical profession here. Said Ms. Luck, "We have fantastic support from the doctors in Helena, but we still need more community involvement. After all, it is a program designed for Helena which has only one hospital.

"With that and the support we have so far, we should be able to make it," she noted confidently.

Among some of the principles involved with the program's implementation are its board of director's members:

David Berg, M.D.
L. H. Blattspieler, M.D.
Leon Claassen, M.D.
Harrison Hanson, M.D.
Lois DeFord, R.N.
Joyce Jacobson, R.N.
Sister Mary Carol, R.N.
Maudie McCauley, R.N.
Ruth Meyers, R.N.
Daisy Prentice, R.N.
Marlene Stellmon, R.N.
Joan Duncan
Rena Sullivan
Cornelia Robinson
Jeannette Folsom
Rex Whitaker
Judy Harkins
Phyllis Miller

The Lewis and Clark Home Health Care Agency is located at 530 N. Ewing. It can be reached at 443-4140.

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officials, and state government.

That system has continually come out on the short end of the stick in competition with other community needs.

Also, it is one whose value is recognized neither by the consumers nor the people responsible for its provision.

Finally, the system has been characterized by fragmentation, inaccessibility, political boundary-guarding, and personnel that are under-paid and over-worked.

The most striking and recurrent reality uncovered by the interview teams is the low priority given public health needs when they are in competition with other community needs. As one interviewer remarked, "County health officers of all counties seem to be at the bottom of the totem pole when the help and concern of county commissioners is needed."

Another significant problem identified is the low, and in several cases almost non-existant, level of awareness of the value of public health services on the parts of the average Montana citizen and those elected or appointed officials charged with making health decisions on the local level.

One team member observed, "On the basis of the interviews with the providers, county commissioners, etc., one could conclude that public health services are being provided satisfactorily."

"In fact," he went on, "they know nothing about the program, and with rare exceptions, it doesn't seem to bother them. They seem to believe this should be someone's responsibility; but it does not really concern them," he concluded.

Another team member expressed the opinion that the ordinary citizen who is not involved with local government or public health service provision is not aware of these services and has very little idea what services he would like to see provided in the future.

As a reflection of this problem, several recommendations were received by the teams to encourage city and county health boards to initiate "better public relations in order to inform the community of the services they provide."

Due in part to the low level of state and local support, public health personnel, where they do exist, were found to be normally over-worked and under-paid. It was noted by one interviewer that most public health workers, especially in those counties with minimal or seriously fragmented services, "only have so much time and they have to cover a lot of area, so they are not always available."

This inaccessibility to public health services compounded by serious transportation problems was seen as a major stumbling block to proper delivery of services.

As the HJR Study Committee had expected, the field investigations revealed that there exists in Montana no standard level of public health services. In many areas of the state, public health services to protect sanitaion or render oher basic public health or medically-related services either do not exist or are inaccessible to a significant portion of the population.

The study has revealed that only three counties in the state, Cascade, Lewis & Clark, and Missoula offer a full range of traditional public health services in any organized or coordinated manner.

Between these three isolated islands lies a vast expanse of uncoordinated and for the most part unorganized public health service delivery. Depending upon the personalities of local elected and appointed officials, members of the local boards of health, and the monetary constraints they must contend with, every county in the state addresses the public health services problem with an individual, fragmented, and often unique approach.

Perhaps most significantly, the study teams reported that despite moves by the past two governors to encourage the creation of district or multi-county organizations for planning purposes and for the delivery of comprehensive services, the issue of political boundaries in public health organization was seen as the major stumbling block to improving public health services for Montanans.

Despite the fact that most counties are financially unable to provide comprehensive traditional health services, most are reluctant to develop a regional approach. There continues to be heavy opposition to any new concept that appears to threaten existing political jurisdiction or erode local power.

Instead, there seems to be either a general dissatisfaction with existing services, however minimal, or the desire to have the state play a greater role in financing local operations.

While local officials identified the present low level of state support for public health services as a problem, they expressed a general unwillingness to accept more state support unless it coincides with the existing local political jurisdictions.

Although a final report has yet to be issued on Step No. 1 of the Study Design for HJR 18, it appears that not all the news about public health services is bad.

There seems to be a general feeling of optimism among most people who were aware of these services. Many reported the opinion that a gradual building of an integrated public health program "That would provide comprehensive services of optimum quality, equally available and accessible to all Montanans is necessary."

Many feel that the state should assure every community of coverage by an official health agency and access to the complete range of public health services.

The consensus seems to be that the state should stimulate and support the development of local health units that would provide the necessary public health services to local communities.

This attitude was tempered by the feeling that though the state and federal support should be increased, the functions and controls which would normally accompany such assistance should be delegated to local health units as much as possible.

Some interviewers reported recommendations for the provision of financial incentives with state aid for any necessary reform in the structure and organization of

(continued on next page

THE READERS' RIGHT

Gentlemen—Friends:

Perhaps it is because I am a native of Montana (born near Billings) transplanted to Oregon that your newsletter seems particularly interesting and good. I do appreciate being on your mailing list even though we are not reciprocating. The Oregon "a" agency does not publish a newsletter and being a lowly "b" agency, ours is a mimeo in-house affair.

However, it is amazing how similar are our problems and our programs. Because of this and because CHP is without many guidelines to follow, it is especially helpful to learn about what others are doing.

Congratulations! You seem to have a very active and worthwhile program. Items in your last publication which I found especially helpful were the ones about development of your state health plan, the one about the home-health care project and the overview of pending Congressional legislation. Of course, this latter may change us all. Our Board of Directors is violently opposing the 500,000 population requirement since in an area such as Oregon (and presumably Montana) it would all but destroy local voluntary participation.

Janet C. Guches
Director
Jackson-Josephine CHP
Medford, Oregon

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local public health organizations to attempt to overcome the resistance of "territory-guarding."

Initial indications are that reorganization and development of new and improved patterns of state districting that would consolidate old local political boundaries will be necessary before rationally-based local health jurisdictions that are financially capable of doing the job can be established.

However, the problem at this point is that the probability of increased state support appears doubtful and an increase in local support seems even more remote until the public is made more aware of the merits of public health programs and related preventive health projects.

The HJR 18 Study Committee is quickly coming to the realization that something must be done to overcome the inertia of the past if a more comprehensive system of public health is to be developed in Montana.

The committee's recommendation to the 1975 session of the legislature is certain to stir a great deal of debate among public, private, and voluntary health principles.

EDITORIAL

BY DAVE TURNER

Nothing makes us more aware of our age and how old we're getting than to experience change. We seem to float along for a while in our own private bubble of reality until . . . POP! Somebody or something pricks it with a pin. For example, take what happened to me recently.

I dropped into my local hardware store last week to pick up some basic fishing supplies — hooks, sinkers, that sort of stuff — and as I was drooling over the vast array of equipment a little gizmo caught my eye. For the life of me I couldn't figure out what it might be used for. It looked simple enough, being nothing more than a foot-tall heavy piece of Y-shaped wire coated with plastic.

I was still standing there turning the thing over and over in my hands when a sales clerk happened by. Knowing full well I hadn't bothered to call ahead for an appointment with the young man, I nonetheless grabbed his sleeve and brashly inquired, "What the hell is this"

Somewhat miffed at being interrupted in his journey from the shotguns to the nail bins, he disdainfully informed me that it was nothing less than their best "Hold-Zem" model, a teflon-coated fishing rod holder.

I couldn't believe it! A teflon-coated steel pole holder!?! At $3.59 apiece, no less! Whatever happened to the "good old days" when you simply whipped out your pocket knife and cut a pole holder from the closest bush?

I found out later that same evening when I trucked on out to the river to fish. An old timer with whom I'm acquainted told me about a secret fishing hole of his and made me promise on his death bed that I'd never reveal its whereabouts to another living soul . . . even under torture.

Well, it must have been a while since he'd fished that hole because when I got there I discovered his "secret" fishing place was not so secret after all. Since he'd been there last, the parking area had been graded and covered with an inch of gravel (keeps your feet dry) and was complete with picnic table, fireplace and a dozen other fishermen.

And wouldn't you know it, there wasn't a bush to cut a pole holder from for miles — they'd disappeared long ago. So there I was with my pole lying in the gravel getting scratched and dusty while up and down the bank everyone else looked over from their aluminum folding chairs and smiled benevolently from behind their Foster Grants, their fishing rods setting high and erect off the ground on those teflon-coated, steel rod holders.

I tell you, the sight of the evening's slowly sinking sun reflecting off the plastic of a dozen rod holders like that was enough to fog over the meter of your electronic, solid-state Fish Detecto device.

Ah, changes. Bobby Dylan forwarned a few years back, "the times, they are a changin'," and I find myself changin' as I leave CHP to begin new adventures in new realms. Seems like not so long ago when I first joined the agency that I was pretty pessimistic about the prospects of health planning, but with time I've come to recognize its worth. Now with new legislation on the federal horizon, I find myself feeling quite optimistic about CHP's potential for really making a positive impact on the health of the people of Montana. And while it may not be teflon-coated, I think in the end it'll get the job done.

One year ago I'd never have thought it possible. Changes. That's what it's all about isn't it?

HEALTH EDUCATION:
Should Result In Behavioral Change
First In a Series on Health Education

Emphasizing the difference between health information and health education, Ms. Alice Heath of the Department of Public Health, Santa Barbara, California, addressed the Second Governor's Conference on Health Education sponsored by the Montana Health Association this past April 15 at the Colonial Hilton Convention Center in Helena.

In an address entitled: "Health Education: Its Promised Potential," Ms. Heath cited the President's Report of the Committee of Health Education, published in 1972, for a definition of health education.

"The report adequately pointed out the difference between the giving of health information which many people think is health education and the changing of behavior in people regarding some health practices which is really health education," Ms. Heath stated.

Heath also referred to another document, the Surgeon General's report in 1964 concerning cigarette smoking, to exemplify her position.

"Perhaps the best documented example of the gap between health information and change in health behavior has been illustrated in the data regarding the smoking pattern at the time of the Surgeon General's report and the situation at the present time. Certainly, there is plenty of information to show the harmful effect of smoking on health."

"Individuals—smokers and non-smokers — given a questionnaire regarding their knowledge of these dangers show that the smokers possess more correct information than the non-smokers. But still the smokers smoke," Heath noted.

"In fact," she went on, "the number of persons smoking is on the increase rather than the decrease—especially in women—in spite of warnings on cigarette packages and other literature available."

According to Heath, the campaign to curb cigarette smoking although informative enough to create initial concern among a good number of smokers, was nevertheless ineffective educationally, because smokers' behavior has not changed dramatically.

Heath proposed three principles to influence people to change their attitudes about health.

"First, involve people early; let it be their project. People need to have some input in determining their own needs."

"Also, start where the people are, not where you think they should be." She outlined her second principle with reference to an experience encountered several years ago in a minority housing project where a baby clinic had been introduced.

—Photo Courtesy Treasurer State News

Heath: "Don't get locked in."

"Only one or two mothers brought their babies to the clinic even though it was easily accessible and had been much publicized."

"And then someone discovered there was serious concern in this small black community that had nothing to do with baby clinics," Heath said.

The concern, it turned out, was for a small stream running past the project which was polluted by raw sewage and had become a popular play area among the project's children.

The speaker indicated that because the property was of such low value, it was not possible politically to have the project's sewage system connected to the main sewer lines.

"The health department staff worked with the people to clean up the community and the property increased in value. They then experienced the voting privilege of circulating a petition and the sewer line went through. The clinic then became full because the people's needs had first been met."

Ms. Heath added: "A third principle of health education is reaching people at their own cultural level. The health aide or community worker has to be accepted in the home to accomplish this. The worker has to know the cultural values of the family and expected practices that might be carried out . . . the role of the father, and the medical superstitutions to mention a few."

The speaker encouraged social workers to foster and improve the relationships they have with the people through direct contacts cautioning: "The rule here is don't get locked into the bureaucracy — keep the innovative processes going."

In concluding, Ms. Heath went on to discuss the importance of patient education stating, "The key person in patient education should be the private or clinic physician. He or she can set the stage for understanding the particular health problem at hand, be it control of a knowing heart condition; the establishment of a program to lose wegiht; or even to understand that the disease the doctor is coping with may be terminal and preparations need be made on the part of the patient and his family to face the inevitable outcome.

"However, with the expansion of health services we are finding that all personnel who come into contact with the patient are needed in the educational process. An example is in the care of the stroke patient wherein nurses, physical therapists, speech therapists and volunteers all play an important role," Ms. Heath emphasized.

Approximately 120 people attended the three-day conference.

THE ARMY: VISIBLE?

Dr. Steven Kairys, M.D., Chief DH&ES Maternal and Child Health Bureau, is coordinating an effort by the United States Army to provide medic and physician services for short periods of time to Montanans.

The Army, in an attempt to increase its visibility in Montana and become involved in public service, has offered to provide their health manpower to communities lacking adequate medical personnel.

Plans for the current year call for the army to provide two or three medics for three to five-day periods and physicians for weekends. It may be possible next year to have the physicians who are Montana reservists spend their two weeks active duty in public service. The specific availability of such personnel and the duration of their visits has yet to be established.

According to Kairys, the reservists could become involved in screening procedures, physical examinations, nursing or lay education, training in emergency care, visiting or evaluation of community residents with chronic or disabling diseases or other services the communities feel are needed.

Toole County authorities have reportedly requested two or three medics for this spring's multiphasic screening. Other communities across the state are being contacted through the local public health nurses to determine their interest in becoming involved with such a program.

Whether or not "Today's Army" will actually join us, its services as a healer are certainly most needed.

Weikel Named Head of Medicaid

Dr. M. Keith Weikel has been named new head of Medicaid. Weikel, who has been acting associate administrator of the Health Services Administration for Planning, will replace Dr. Howard Newman who has resigned. Weikel previously headed an HEW task force that worked out Secretary Caspar Weinberger's lowest cost drug policy. Weikel was with Roche Laboratories before joining HEW in 1970.

Advisory Council Meets

Meeting in Helena, the Advisory Council conducting business.

In actions taken at its last meeting held May 18 in Helena, the Advisory Council for Comprehensive Health Planning elected a chairman and vice-chairman, approved the rough draft of the State Plan for Health, and approved the election of chairpersons to the six standing committees.

The 25-member council is the body which approves the expenditures of Hill-Burton funds in Montana, reviews and comments upon approximately 36 federal health programs in the state, and guides the modernization and building of hospitals and other medical facilities receiving Medicaid, Medicare, and Maternal and Child Health funds.

Donald Pizzini, Health Officer of the City-County Health Department in Great Falls, was elected new chairman of the Advisory Council in a unanimous decision. Pizzini, 36, has been associated with CHP since 1968 and has been an influential member of the Environmental Health Committee. He will succeed William Leary, Executive Director of the Montana Hospital Association.

In other action, the Advisory Council approved the rough draft of the State Plan which upon completion will help guide the expenditures of health funds throughout Montana. It is hoped that the final approval and publication of the Plan will take place later this summer.

Finally, the Council approved the chairpersons elected by the six standing committees. Following is a list of those persons and their respective committees:

Donald Pizzini, City-County Health Department, Great Falls, Executive Committee;

Violet Butterfly, VISTA Supervisor, Browning, Services Committee;

Anita Richards, SOS Health Center Board, Seeley Lake, Manpower Committee;

George Clark, Hospital Administration, Kalispell, Facilities Committee;

Grace Bates, Gallatin Co. Health Planning Council, Manhattan, Areawide Committee;

Martha Dow, Microbiologist, Havre, Environmental Health Committee.

SPECIAL SECTION

National Health Legislation: Where Is It Now?

Because there is much happening on Capitol Hill relating to pending legislation on health matters, a special section is being devoted to bills currently being reviewed by our elected officials. The bulk of the information contained in this section was provided by WASHINGTON REPORT ON MEDICINE AND HEALTH and the South Central Regional Health Planning Council.

Although much if not most of the talk on national health legislation seems to be concerned with the myriad of happenings surrounding pending Congressional action on national health insurance, there are currently four other health-related bills before Congressional committees.

Undoubtedly to be of major proportions, the results of those committee hearings could quite possibly be the product of some compromising. Also, it is expected that the National Governors' Conference, the National Association of Counties and the National Conference of Mayors may seek sponsorship of their own versions of health planning legislation.

Quite regardless of the provisions of the actual legislation to be enacted, it seems almost certain that there will be emphasis on the role of government in health planning at all levels including political and geographical ones.

For the health consumers, the picture is anything but rosy. The SCRHPC has provided **CHP NEWS** with an overview of the four major pieces of legislation presently under consideration. The indication from the overview is that "the voice of a majority of the non-health providers and the non-governmental officials which have been referred to as the consumer under P.L. 89-749 as amended, will most assuredly diminish in numbers from a majority to something less."

Another provision which is most likely to effect the present structure of areawide agencies will be Boards of Directors' number and structures according to the overview which also interprets the "consolidating, redistricting, or phasing out of present areawide agency areas based on population of 500,000" as being even more dramatic.

The committees reviewing the bills are: Senate Labor and Public Welfare and the House Interstate and Foreign Commerce Committees.

MAJOR PROVISIONS OF LEGISLATION

Area Agencies: Organization and Governing Board.

H.R. 12053 — National Health Policy and Health Development Act of 1974 — Non-profit private corporation. Governing board 10-30 members (⅓ consumers, ⅓ providers, ⅓ public elected officials.) Establishes Health Service Agencies (HSA).

S. 2994 — National Health Planning and Development Act of 1974 — Non-profit private corporation. Governing Board 10-30 members. Provisions the same as H.R. 12053. Establishes Health Planning Agencies (HPA).

P.L. 89-749 — Comprehensive Health Planning and Public Health Services Amendments of 1966 — Non-profit private corporation, or other public organization. Size of governing board does not specify minimum or maximum, but must have a consumer majority. Amended to include appropriate representation of the interests of local government where the agency is not a governmental unit (P.L. 90-174).

H.R. 13472 and S. 3166 — Health Resources Planning Act of 1974 — 'Public Benefit Corporation' not for profit, incorporated in state which it is located. Governing Board: 12-30 members (½ consumers, ⅓ providers, ⅓ elected public officials.) Establishes Health Planning Agencies (HPA).

S. 3139 — Health Planning Act of 1974 — 'Public Benefit Corporation' not for profit, incorporated governing board 10-30 members (⅓ consumers, ⅓ providers, ⅓ elected public officials.) Establishes Health Planning Agencies (HPA).

AREA DESIGNATIONS AND POPULATION CONSIDERATIONS

H.R. 12053 — Priority designation to existing areawide CHP agencies and to Regional Medical Projects; population 500,000 to 3,000,000 (or more if in SMSA). Provides establishment of subarea advisory councils.

S. 2994 — Approval by Governor of each state before Secretary designates; population 500,000 to 3,000,000 (or more if in SMSA). Provides establishment of subarea advisory councils.

P.L. 89-749 — Approval of State agency administering or supervising the State Plan. Population basis is not specified, except a unit feasible for health planning purposes. Agency may cross state boundaries.

H.R. 13472 and S. 3166 — Designated by chief executive officer of each state after consulting with existing state and local officials; the Secretary would certify the planning agencies — not to cross boundaries of an SMSA, unless unfeasible. Population 500,000 to 3,000,000 (or more if in SMSA).

S. 3139 — Established by Governors of each state subject to approval by the Secretary. Area to follow state boundaries, except by an interstate compact to combine two or more areas established by states. Population 500,000 to 3,000,000 (or more if in SMSA). Provides establishment of subarea advisory councils.

STAFFING

H.R. 12053 — Minimum of five professional staff with expertise in (1) data gathering and analysis;

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A Reality Soon?

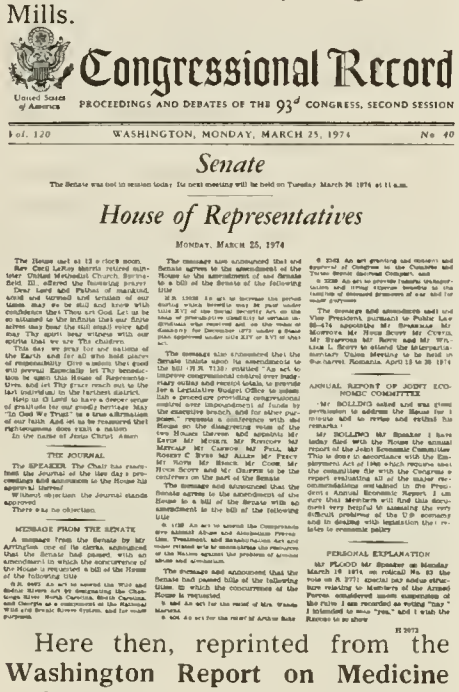
NATIONAL HEALTH INSURANCE

It is pretty much common knowledge even among those far removed from Capitol Hill what is on the minds of those working between Constitution and Independence Avenues at present.

Amid the continuous clamor of Watergate, impeachment, energy concerns, and pending legislation, there are those proponents of national health insurance who, if not overshadowed completely by an imminent decision by the House Judiciary Committee, may yet pass a National Health Insurance Bill before the 93rd Congress runs out of energy, time, or both.

During the last weeks of April, the House Ways and Means Committee began hearings on national health insurance. According to the April 29 edition of **Washington Report on Medicine and Health,** the committee members had an opportunity to "vent their spleens" a bit on the matter before Chairman Wilbur Mills (D.-Ark.) requested that the witnesses concentrate on three major bills: the Administration's, the Kennedy-Mills' proposal, and Ullman's.

However, Rep. Martha Griffiths (D.-Mich.) announced her intention to continue fighting for the cradle-to-grave plan (S.3) supported by organized labor that Kennedy has downplayed since joining with Mills.



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THE JOURNAL

MESSAGE FROM THE SENATE

ANNUAL REPORT OF JOINT ECONOMIC COMMITTEE

PERSONAL EXPLANATION

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Here then, reprinted from the **Washington Report on Medicine and Health,** is a review of some of the important provisions in pending NHI bills. It is intended that the analysis be issue-oriented.

Nixon Administration Bill
(S. 2970, H.R. 12684)

The bill would require employers to provide **private health insurance** for employees. There would also be a federally-assisted plan for **low income and high medical risk individuals.** The aged would be covered by a new Medicare program.

Under the **private insurance plan,** the employer would pay 65% of the premium of the first three years and 75% thereafter, with a federal subsidy for small and low wage employers. The average premium for a full-time employee would be $415. **The second plan** would be financed through federal and state contributions to premium payments for families with incomes less than $5,000 per year. The **new Medicare plan** would operate on the trust fund and a $90 a year annual premium.

Mills-Kennedy Bill (compromise)
(S. 3286, H.R. 13870)

Unlike the previous bill, which is compulsory only for the employer, Mills-Kennedy would have a system required for all U.S. residents except those eligible for Medicare. Also, Mills-Kennedy would establish **a new National**

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Health Legislation—

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(2) planning; and (3) health manpower, facilities and services.

S. 2994 — Same provisions as H.R. 12053.

P.L. 89-749 — No standards established. No specified minimum staffing or expertise. However, this area is subject to review each year upon submission of grant application to State Health Planning and CHP Regional Office.

H.R. 13472 and S. 3166 — To include individuals knowledgeable in health care financing, organization, and resource allocation; may employ consultants or contract with individuals or groups for the provision of services.

S. 3139 — Same provisions as H.R. 12053 including the review of professional credentials and competence of the staff by the Secretary.

REVIEW AND PLANNING ACTIVITIES

H.R. &12053 — Establish an annual short-term priorities plan and a long-range goal plan. Coordinate activities with each Professional Standards Review Organization, State Health Commission, and appropriate regulatory agencies. Assist the 1122 program for Capital Expenditures Review.

S. 2994 — Same provisions as found in H.R. 12053 with the addition of reviewing rates charged or proposed by health care providers under provisions of the act Section 627 (a) (8)-with recommendations to the State Health Commission on an annual basis.

P.L. 89-749 — Relates to all other programs supported by the federal government such as health planning grants to states; CHP training, studies and demonstrations; formula grants; health service development-project grants; Regional Medical Programs, etc.

H.R. 13472 and S. 3166 — Same provisions as found in H.R. 12053 with the exceptions that the 1122 program is not addressed in the bill directly to the HSA's (see Special Features).

S. 3139 — Each agency would review existing or proposed health services by following procedures and applying criteria developed and published by the HSA in accordance with regulations of the Secretary (State Health Commission would follow procedures and applying criteria developed and published by the HSA in accordance with regulations of the Secretary. State Health Commission would follow procedures, etc. as outlined by the Secretary). Other provisions are similar to those covered in H.R. 12053 above.

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NHI – Late Developments

June 1 — Political maneuvering principally on the part of organized labor may in effect postpone until next year's 94th Congress legislation on National Health Insurance.

The apparent move by labor to stall is essentially an attempt to buy more time from Congress. As is evident from recent Congressional elections, Republican strength is waning in the wake of Watergate; and the prospects for a strong Democratic majority next year are being vied by labor as a more favorable climate for the bill of its choice.

Specifically, organized labor is hardening its opposition to the Mills-Kennedy National Health Insurance bill (see article on NHI). Such a stand by labor is causing some concern among the "liberal strategists" of national health insurance.

If Congress should awaken to the fact that labor is unwilling to compromise its backing of the original Kennedy Health Security bill, then chances of a free-standing catastrophic bill's slipping through are improved. Hence, the concern is most warranted.

It is believed that Sen. Russel Long, (D., La.) has taken this situation into consideration as he has scheduled hearings later this month on national health insurance. Long is author of a bill which includes the catastrophic provision.

Should Congress take what some view as the "easy way out" and settle for the catastrophic section of the bill co-sponsored by Long and Ribicoff, it is deemed difficult that a more liberal bill such as Health Security could get through next year.

MILLS-KENNEDY: SINCERE

Leonard Woodcock, President of the United Auto Workers' Union and head of the Committee for National Health Insurance — which wrote the Health Security, told the House Ways and Means Committee in May that he finds the Mills-Kennedy bill a "sincere effort" that "won't do the trick."

The UAW boss wasn't alone in his disenchantment with Mills-Kennedy as the AFL-CIO Executive Council issued a Statement at the same time voicing its frank disappointment with the Mills-Kennedy bill.

AFL-CIO President George Meany — a consistent critic of Administration policy — was scheduled to testify in mid-May before the Ways and Means Committee and was expected to say the same thing.

However, it has been reported that labor officials were privately saying that they would be willing to settle for Mills-Kennedy but that they are adamant about seeing a compromise no less than that. No doubt the labor leaders would have some difficulty accounting to their membership a public rollback from Health Security.

A bit of irony prevailing, it turned out that those seeking a first-hand witnessing of a dialogue between George Meany and House Ways and Means Committee Chairman Wilbur Mills on National Health Insurance were disappointed.

For the hearings scheduled to begin around the second of May, neither of the two showed up. The reasons—health. A recurrent back ailment was reportedly plaguing Mills while Meany was said to be out with a cold.

Meany was represented at the hearings by AFL-CIO chief lobbyist Andrew J. Biemiller who made it known that the labor federation was well aware of talk on compromise between labor's Health Security National Health Insurance bill and the others.

But, Biemiller said, if the Mills-Kennedy bill is "the committee's idea of a compromise, then I must say, in all candor, we will oppose it."

Aware that NHI may well be a major issue in the fall elections, Biemiller pursued the hardening labor stand that Congress should not "rush into compromises but rather wait until next year when the 94th Congress can then take up National Health Insurance as its number one priority."

Meanwhile, in a related development, the Mills-Kennedy bill picked up an important new backer—Sen. Jacob Javits (R., N.Y.). The Senator who has put in his own NHI bill in the past, announced his support for the bill in a speech before Yeshiva University's Albert Einstein College of Medicine in New York.

The National Level

There is a tenuous dichotomy these days between ecological concerns and the so-called "energy crisis." And it now appears that one of the recent victims within the legislative arena has been clean air.

Late in May, the Senate voted to delay for two years until 1977, the deadline date set for the auto industry to reach emission standards.

Less stringent than the House bill, the Senate bill would for a period of time adjust air standards to allow for the utilization of coal in lieu of other fuels in short supply.

* * *

The House Education and Labor Committee has approved a bill (HR 13768) to extend coverage of the National Labor Relations Act to employees of non-profit hospitals. The House bill is similar to the Senate-passed bill (S 3203).

* * *

Although the House Health Subcommittee completed hearings in May on health planning legislation, a finalized version in the form of a bill was scheduled for sometime in June at the earliest due to a flood of other bills demanding the attention of sub-committee members.

Like Senate Health Sub-committee Hearings on similar legislation, the House hearings were for the most part rather mundane. The general attitude pervailing among the witnesses, sub-committee members, and spectators was reported to have been one of disinterest stemming from the House panel's decision to drop the idea of rate regulation from the bill.

Chairman Senator Philip A.

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National Health Insurance—

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Health Insurance trust fund separate from the existing Medicare trust fund.

Employees would pay into the NHI fund no more than one percent and employers at least three percent payroll tax on the first $20,000 of wages. The bill also provides **reduced cost sharing for low-income individuals,** the money coming from federal revenues and the states.

Long-Ribicoff Bill
(S. 2513, H.R. 14079)

Emphasis of this bill is catastrophic coverage and a revamped Medicaid program to cover the "working poor" in addition to low-income individuals. Participation is voluntary. Long-Ribicoff also seeks to encourage the availability of private health insurance policies and establishment of insurance pools.

Under the catastrophic plan, employers, employees and those self-employed would pay into a separate trust fund 0.3% of earnings for the first three years during which time federal revenues would be added to the fund. The new medical assistance program would bring in the so-called working poor, allowing them to become eligible by deducting medical expenses from income.

Griffiths-Kennedy Bill
(S. 3, H.R. 22)

The bill stresses a broad national program of compulsory participation, financed by payroll taxes and federal revenues. A new trust fund would be created, with employers paying 3.5% tax on entire payroll and employees one percent on the first $15,000 of earnings.

Other National Health Insurance Bills

The American Hospital Association's bill (H.R. 1) by Rep. Al Ullman (D. Oreg.) would require employers to pay at least 75% of premiums with federal subsidies for low-income workers and for subscribers of new national health care corporations. The "Medicredit" bill (S. 444), supported by the American Medical Association, is a voluntary system of income tax credits for health insurance premiums. The Health Insurance Association of America supports a bill (H.R. 5200) which offers incentives for employers and individuals to purchase private plans.

ADMINISTRATION AND QUALITY ASSURANCE

Nixon Administration Bill
(S. 2970, H.R. 12684)

Private insurance companies would offer the basic plan approved by the states, which would be under regulations of HEW's Social Security Administration. Reimbursement rates would be established by states, according to federal criteria. The states would certify providers.

Long-Ribicoff Bill
(S. 2513)

Both the catastrophic insurance and the medical assistance plan would be administered by SSA's Bureau of Health Insurance and Medicare fiscal intermediaries. The bill incorporates the quality assurance and utilization review provisions of the 1972 Social Security Amendments.

Mills-Kennedy Bill
(S. 3, H.R. 22)

Administration would be by an independent SSA headed by a three-member board and fiscal intermediaries. Payments to institutional providers would be on the basis of a variety of prospective payment systems with incentive payments to better-performing providers.

Griffiths-Kennedy Bill
(S. 3, H.R. 22)

The President would name a Health Security Board within HEW, which would administer the program and establish quality and costs of services. The bill establishes at the federal level a Commission on the Quality of Care, to continually review the standards and regulations for care paid by the security board.

BENEFITS

After an individual paid $1,500 in cost sharing under the regular plan or $750 under Medicare, catastrophic benefits would be provided by the Nixon Administration bill. Also included is unlimited hospital and physician care and mental health and other medical care subject to deductables and copayments.

Benefits are similar in the Mills-Kennedy bill, except that a new program would be created for a long-term care. The Long-Ribicoff bill would begin catastrophic coverage after $2,000 was spent.

Under the Kennedy-Griffiths bill, complete hospital and medical care would be covered without deductables or copayments.

COMINGS/GOINGS

With the advent of spring, there comes also a change among the faces of the Montana CHP scene. Sandra Nicholson, Health Planner for EDAEM, has left CHP reportedly because someone made her an offer she could not refuse: matrimony. The Board of EDAEM has selected Mr. Richard Eudy as Sandy's replacement. Rich, who holds a M.A. degree in counseling and a B.A. in psychology from the University of Montana, began work in mid-March and will continue the areawide organizational work and health plan which Sandy had begun. A native of Havre, Eudy will be operating out of Sidney.

State CHP's environmental planner and most recent editor of the MCHP NEWS, Dave Turner, has also left CHP to pursue his interest in the pastoral tranquility of eastern Iowa. Replacing Dave is Jim Jasper. Hailing originally from the Chicago area, our new editor has a B.A. in journalism and philosophy from Marquette University, A former VISTA volunteer for the past two years, Jasper's inheritance has been one Underwood Typemaster and a mobile which Dave couldn't find room to pack.

The National Level—

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Hart's (D., Mich.) Anti-trust Monopoly Sub-committee heard hearings in May on the existence of competition among providers of health care.

Intended to discover whether or not increased competition in the health care industry would work to the benefit of consumers, the hearings saw witnesses attempt to show among other things that Health Maintenance Organizations could bring greater competition while organized medicine can at times stifle it.

Health Legislation—

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REGULATORY ACTIVITIES

H.R. 12053 — To review and approve or disapprove federal programs in Facilities Construction for Mental Health and Retardation, Alcohol Abuse and Treatment, and assist in the 1122 program.

S. 2994 — Covers the provisions found in H.R. 12053 and review health services proposed to be offered in the area.

P.L. 89-749 — Prohibits interference with the private practices of medicine, dentistry and the related healing arts.

H.R. 13472 and S. 3166 — Addresses state regulatory activities by providing a formula grant program upon the participation in the capital expenditures review program. &"Recognizes that regulation of the health care industry is a governmental function and cannot appropriately be transferred to private hands."

S. 3139 — Requires each HPA to review on a periodic basis the health services offered or proposed in the health area of the agency providing recommendations to the State Health commission. Where such a service cannot be certified, the health planning agency shall work with the provider or proposed provider (and other entities) for improvement or elimination of the service. After initial certification by the State Health Commission, the health service in the area shall be reviewed at least every five years by the HPA.

SPECIAL FEATURES

H.R. 12053—

(1) Establishes a National Council for Health Policy within the Executive Office of the President.

(2) Establishes State Health Commissions, independent within the state government and the agency for performance of regulatory functions. Governing body of 3, 5, or 7 fulltime members appointed by the governor for staggering terms not less than four

S. 2994—

(1) Secretary would initiate guidelines on national health policy including a statement of national health goals.

(2) Establishes State Health Commission which is not an independent agency within state government. Governor appoints advisory council (budget and performance advice). Two-thirds of the advisory council shall be individuals who are not health care providers.

(3) Health planning agencies combine the functions of existing areawide health planning agencies and Regional Medical Programs.

P.L. 89-749—

(1) Assures comprehensive planning for health services, health manpower, and health facilities. Strengthens leadership and capacities of state health agencies and support of health services provided to people in their communities "but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts."

(2) Establishes a state health planning council to include representatives of state and local agencies and non-governmental organizations, health professionals and consumers — a majority of such a membership to be representatives of health services of consumers.

H.R. 13472 and S. 3166—

(1) Establishes a Statewide Health Coordinating Council but does not specifically call for a State Health Council where regulatory authority is housed.

(2) Secretary of HEW would authorize a 25% increase in the state's allocation if the state agrees to regulate capital expenditures and agrees to certain rate regulatory responsibilities.

(3) The Statewide Health Coordinating Council would be established by two or more HSA's and be comprised of at least two members of each HSA (one a consumer

al, the other a pro-

SA will assume a
hare of the costs
ealth Coordinating
t to be established
y). The state would

(5) Establishes the HSA's as "public benefit corporations, a unique and successful legal concept in New York State which provides greater authority and flexibility in management and operation." (Javits, Rep. N.Y.)

S. 3139—

(1) "In lieu of Federal intervention into state public health police powers where a state fails to comply with the provisions of the bill, the bill rather withdraws all federal funding programs support." (Javits.)

(2) Establishes health planning agencies as "public benefit corporations" as in S. 3166.

(3) Sets procedures and criteria for reviews of proposed health system changes.

(4) Establishes State Health Commissions (designation of State Health Commissions) determined by the Secretary on a trial basis (not to exceed 24 months). The Secretary shall recognize the agency designated by the Governor on a conditional basis. Conditions of recognition are detailed in the bill.

FUNDING

H.R. 12053 — Provides 100% federal funding and guarantees a minimum of $150,000 per agency. Provides a federal match for local funds but limits local match to no more than 5% from any one private contributor. Funding to June 30, 1976.

S. 2994 — Provides federal funding similar to H.R. 12053 and allows non-federal funds for match with the exception that no part of the funds can be contributed by private contributors. Funding to end June 30, 1977.

P.L. 89-749 — Provides federal support not to exceed 75% of costs. Funding to June 30, 1973 with one year extension granted to June 30, 1974.

H.R. 13472 and S. 3166 — Provides unconditional contributions from any private source of up to 5% of assistance from the Secretary and up to 25% of the amount from any public sources. (Amounts to be established by the Secretary.)

S. 3139 — Provides for funding support similar to H.R. 12053.

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